STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING _____ B. WING _____	C 03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	**114 S CHESTNUT ST HUNTINGBURG, IN 47542**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for a full recertification and state licensure survey. This visit included the investigation of Complaint #IN00191094. Complaint #IN00191094: Substantiated, no deficiencies related to the allegation(s) were cited. Dates of Survey: 3/16, 3/17 and 3/18, 2016 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 Transitional Services Sub LLC was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the recertification and state licensure survey and to the investigation of complaint #IN00191094. Quality Review of this report completed by #15068 on 3/24/16.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE